STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001062	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, LLC	**8424 NAAB ROAD, SUITE 3G** **INDIANAPOLIS, IN 46260**

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K 000	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 02/03/16 Facility Number: 008902 Provider Number: 15C0001062 AIM Number: 200119350A At this Life Safety Code survey, Northside Gastroenterology Endoscopy Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This facility, located in a one story building was determined to be of Type V (000) construction and was nonsprinklered. The facility has a fire alarm system with smoke detection in the corridors.	K 000		
K 029	Quality Review completed on 02/04/16 - AK 416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2	K 029		2/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

02/25/2016

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 3 hazardous areas, such as a medical records storage room, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. LSC 39.3.2.1 refers to LSC 8.4. LSC 8.4.1.3 requires doors in barriers to be self-closing or automatic-closing in accordance with 7.2.1.8. This deficient practice could affect any patient in the facility. Findings include: Based on observation on 02/03/16 at 11:10 a.m. with the Executive Director and Nurse Manager, the medical records storage room was used to store a large volume of paper files stored in a sliding file cabinet systems lacked a self-closing device on the room door. Based on interview, this was acknowledged by the Executive Director and Nurse Manager at the time of observation.	K 029		
K 046	416.44(b)(1) LIFE SAFETY CODE STANDARD Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 5 of 5 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than	K 046		2/18/16

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K 046	Continued From page 2 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all patients and staff. Findings include: Based on review of preventive maintenance documentation on 02/03/16 between 9:40 a.m. and 12:00 p.m. with the Executive Director and Nurse Mangaer present, there was no documentation available to show an annual 90 minute test for all five battery operated emergency light sets. Monthly testing documentation indicated there was a battery operated emergency light set in each of the four procedure rooms and one in the mechanical room. Based on interview during the exit conference, the Executive Director acknowledged there was no documentation to show an annual 90 minute test was conducted for the five battery operated emergency light sets during the most recent twelve month period.	K 046		
K 048	416.44(b)(1) LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 20.7.1.1, 21.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a complete written policy for the	K 048		2/18/16

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K 048	Continued From page 3 protection of all patients containing procedures to be followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC Section 9.6.1.8. This deficient practice could affect all patients, as well as staff, and visitors in the facility. Findings include: Based on review of the policy, " Fire Watch: Protocol for Fire Alarm Out of Service" with the Executive Director on 02/03/16 at 11:40 a.m., the fire watch policy and procedure did not include the Indiana Department of Health (ISDH) as an "Authority Having Jurisdiction" and only indicated the "Fire Marshal" as the Authority Having Jurisdiction. Based on interview during the exit conference, the Executive Director acknowledged the fire watch policy did not recognize the ISDH as an Authority Having Jurisdiction and the policy did not include contacting the ISDH in the event of an inoperative fire alarm system placed out of service for 4 hours or more in a 24 hour period.	K 048		
K 050	416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2 This STANDARD is not met as evidenced by: Based on review of fire drill documentation and interview, the facility failed to conduct 4 of 4 fire drills at unexpected times. This deficient practice affects all occupants in the facility including staff,	K 050		2/19/16

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K 050	Continued From page 4 visitors and patients. Findings include: Based on review of the "C9-74 Fire Drill Report" documentation with the Nurse Manager at 9:40 a.m. on 02/03/16, fire drills were not conducted at unexpected times in that three of the four drills conducted in 2015 were conducted between 3:00 p.m. to 4:00 p.m. on 03/26/15, 03/30/15 and 09/28/15. The fourth drill was conducted at 4:50 p.m. on 12/31/15. Based on interview at the time of review, the Nurse Manager acknowledged the fire drills conducted during 2015 occurred at similar times in the evening and similar dates near the end of the month.	K 050		
K 064	416.44(b)(1) LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided. 20.3.5.2, 21.3.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to inspect 2 of 6 portable fire extinguishers each month. LSC 21.3.5.2 requires fire extinguishers be provided in accordance with 9.7.4.1. LSC 9.7.4.1 requires portable fire extinguishers shall be installed, inspected and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" that a fire extinguisher is available and will operate. It is intended to give reasonable	K 064		2/19/16

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K 064	Continued From page 5 assurance that the fire extinguisher is fully charged and operable, verifying that it is in its designated place, that it has not been actuated or tampered with, and that there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observation on 02/03/16 between 11:00 a.m. and 11:30 a.m. with the Executive Director and Nurse Manger, the monthly inspection tag attached to the portable fire extinguisher located in the employee break room lacked documentation of a monthly inspection for December, 2015 and the monthly inspection tag attached to the portable fire extinguisher located near the pre-op entrance lacked documentation of a monthly inspection for January, 2016. The annual inspection for all six extinguishers occurred in March, 2015. Based on interview, this was acknowledged by the Executive Director and Nurse Manager at the time of observation.	K 064		
K 075	416.44(b)(1) LIFE SAFETY CODE STANDARD Solid linen or trash collection receptacles shall not exceed 32 gallons (121L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4L/m2). A capacity of 32 gal (121L) shall not be exceeded with any 64 ft2 (5.9m2) area. Mobile soiled linen or trash collection receptacles with capacity greater than 32 gallons (121L) shall be located in a room protected as a hazardous area when not attended. 20.7.5.3, 21.7.5.5	K 075		2/11/16

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K 075	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure a capacity of 32 gal for mobile soiled linen or trash collection receptacles was not exceeded within any 64 sq. foot area. LSC 21.7.5.5 states, a capacity of 32 gal (121 L) is not exceeded within any 64 square foot area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. This deficient practice could all patients, staff and visitors. Findings include: Based on observation on 02/03/16 between 11:00 a.m. and 11:30 a.m. with the Executive Director and Nurse Manger, there were two receptacles with cloth bags used for soiled linen at the prep nurse's station next to each other within a 64 square foot area. Based on interview, at the time of observation, the Nurse Manager thought the bags had a 30 gallon capacity but was unsure. The Executive Director and Nurse Manager checked an unused bag for any labels indicting capacity but was unable to confirm the size. The Executive Director indicated he would check with the supplier.	K 075		
K 114	416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded	K 114		2/11/16

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K 114	Continued From page 7 core wood of 1¾ inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors, are fixed fire window assemblies in accordance with 8.2.3.2.2. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain 1 of 1 one hour fire barriers separating it from an adjoining tenant. LSC Section 21.3.7.1 requires ambulatory health care facilities to provide walls with one hour fire resistance rating for tenant separation. LSC 21.3.7.3 requires any smoke barrier to be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than one hour. LSC Section 8.3.6.1 states annular spaces caused by penetrations in fire barriers from pipes and conduits shall be filled with a material capable of maintaining the fire resistance of the fire barrier or by an approved device designed for the specific purpose. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier. Findings include: Based on observation on 02/03/16 between 11:00 a.m. and 11:30 a.m. with the Executive Director, penetrations filled with an orange colored expandable foam were noted in the tenant separation fire wall above the procedure hallway door, the lobby entrance door and several other points along the wall. Based on interview at the time of the observations, the Executive Director acknowledged the aforementioned openings in the tenant separation fire barrier were filled with	K 114		

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K 114	Continued From page 8 the orange foam material 2 to 3 years ago but lacked documentation to substantiate the material was tested and approved as a through penetration fire stop.	K 114		